		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011528

Facility Name: Meadow Manor

Address: 800 McAdam Drive (Number) Taylorville (City) 62568 (Zip Code)

County: Christian

Telephone Number: 217 824-2277 **Fax #** 217 287-7763

IDPA ID Number: 370840530001

Date of Initial License for Current Owners: 1963

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jerry W. Jennings **Telephone Number:** 217 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 05/01/99 to 04/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Jerry W. Jennings

(Title) Controller

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	150	Intermediate (ICF)	150	54,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	21,603	8,218		29,821	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,603	8,218		29,821	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.32%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1963

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 4/30/00 Fiscal Year: 4/30/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number # Report Period Beginning: Ending:

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	107,975	14,591	3,456	126,022		126,022	0	126,022			1
2	Food Purchase		101,124		101,124		101,124	(1,975)	99,149			2
3	Housekeeping	38,596	13,539		52,135		52,135	0	52,135			3
4	Laundry	23,716	15,533		39,249		39,249	0	39,249			4
5	Heat and Other Utilities			70,515	70,515		70,515	(4,200)	66,315			5
6	Maintenance	43,023	25,627	31,274	99,924		99,924	2,508	102,432			6
7	Other (specify):* Utility Workers	14,741			14,741		14,741	0	14,741			7
8	TOTAL General Services	228,051	170,414	105,245	503,710		503,710	(3,667)	500,043			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	0	12,000			9
10	Nursing and Medical Records	730,173	29,109	7,684	766,966	(4,047)	762,919	479	763,398			10
10a	Therapy	16,414	49		16,463		16,463	0	16,463			10a
11	Activities	22,174		1,538	23,712		23,712	0	23,712			11
12	Social Services	10,890		2,835	13,725		13,725	0	13,725			12
13	Nurse Aide Training	3,582	90	5,232	8,904		8,904	0	8,904			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	783,233	29,248	29,289	841,770	(4,047)	837,723	479	838,202			16
	C. General Administration											
17	Administrative	45,127		8,694	53,821	696	54,517	37,918	92,435			17
18	Directors Fees							0				18
19	Professional Services			159,626	159,626		159,626	(150,020)	9,606			19
20	Dues, Fees, Subscriptions & Promotions			9,875	9,875		9,875	(3,833)	6,042			20
21	Clerical & General Office Expenses	16,555	6,041	5,918	28,514		28,514	16,578	45,092			21
22	Employee Benefits & Payroll Taxes			138,874	138,874		138,874	9,297	148,171			22
23	Inservice Training & Education			1,939	1,939		1,939	167	2,106			23
24	Travel and Seminar			1,615	1,615	(939)	676	696	1,372			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			47,142	47,142		47,142	279	47,421			26
27	Other (specify):*			18,389	18,389		18,389	(18,389)				27
28	TOTAL General Administration	61,682	6,041	392,072	459,795	(243)	459,552	(107,307)	352,245			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,072,966	205,703	526,606	1,805,275	(4,290)	1,800,985	(110,495)	1,690,490			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number # Report Period Beginning: Ending:

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			27,297	27,297		27,297	5,218	32,515			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			24,522	24,522		24,522	(267)	24,255			32
33	Real Estate Taxes			27,904	27,904		27,904	0	27,904			33
34	Rent-Facility & Grounds							3,962	3,962			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			79,723	79,723		79,723	8,913	88,636			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					4,290	4,290	0	4,290			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			82,350	82,350		82,350	0	82,350			42
43	Other (specify):*							0				43
44	**TOTAL Special Cost Centers**			82,350	82,350	4,290	86,640		86,640			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,072,966	205,703	688,679	1,967,348	0	1,967,348	(101,582)	1,865,766			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number # Report Period Beginning: Ending:

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(4,200)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,502	30		9
10	Interest and Other Investment Income	(267)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,690)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,412)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(60)	20		17
18	Fines and Penalties	(6,727)	27		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,257)	27		24
25	Fund Raising, Advertising and Promotional	(3,147)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(993)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(819)	20		28
29	Other-Attach Schedule Vending	(1,975)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (27,045)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(76,369)	Various	34
35	Other- Attach Schedule Sch XIX-H Column 8	1,832	6	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (74,537)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (101,582)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule Oxygen	X		4,290	10	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 4,290		47

Print Preview

Detail lines 29 and 35 of Page 8 starting in B44. DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 8A**

Facility Name _____

ID# _____

Report Period Beginning: _____

Ending: _____

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure not to highlight rows 45 thru 62.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	0
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	0	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	(6,207)
6	**Rented Facility Space**	(4,200)	5	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	0
8	**Laundry for Non-Patients**	0	0	**Line 8**	(9,200)
9	**Non-Straight-line Depreciation**	1,502	10	**Line 9**	0
10	**Interest and Other Investment Income**	(267)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	(1,690)	21	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(3,412)	27	**Line 12**	0
14	**Non-Care Related Interest**	0	0	**Line 12**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 13**	0
16	**Personal Expenses (Including Transportation)**	0	0	**Line 15**	0
17	**Non-Care Related Fees**	(60)	26	**Line 16**	0
18	**Fines and Penalties**	(6,727)	27	**Line 17**	0
19	**Entertainment**	0	0	**Line 18**	0
20	**Contributions**	0	0	**Line 19**	0
21	**Owner or Key Man Insurance**	0	0	**Line 20**	(4,000)
22	**Special Legal Fees & Legal Retainers**	0	0	**Line 21**	(1,000)
23	**Life Insurance Insurance for Individuals**	0	0	**Line 22**	0
24	**Bad Debt**	(7,207)	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(3,147)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement Taxes**	(991)	27	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	(819)	20	**Line 27**	(16,305)
29	**Non-Paid Workers**	0	0	**Line 28**	(24,165)
30	**Donated Goods**	0	0	**Line 29**	(75,502)
31	**Amortization Expense**	0	0	**Line 30**	3,000
32				**Line 31**	0
33				**Line 32**	(687)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	2,000
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(99,566)

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number _____ # _____ Report Period Beginning: _____ Ending: _____

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,200)	0	0	0	0	0	0	0	0	0	0	(4,200)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,200)	0	0	0	0	0	0	0	0	0	0	(4,200)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	312	0	0	0	0	0	0	0	0	0	312	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(150,260)	0	0	0	0	0	0	0	0	0	(150,260)	19
20	Fees, Subscriptions & Promotions	(4,026)	0	0	0	0	0	0	0	0	0	0	(4,026)	20
21	Clerical & General Office Expenses	(1,690)	0	0	0	0	0	0	0	0	0	0	(1,690)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(312)	0	0	0	0	0	0	0	0	0	(312)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(18,389)	0	0	0	0	0	0	0	0	0	0	(18,389)	27
28	**TOTAL General Administration**	(24,105)	(150,260)	0	0	0	0	0	0	0	0	0	(174,365)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(28,305)	(150,260)	0	0	0	0	0	0	0	0	0	(178,565)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **#** **Report Period Beginning:** **Ending:**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	3,502	0	0	0	0	0	0	0	0	0	0	3,502	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(267)	0	0	0	0	0	0	0	0	0	0	(267)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,235	0	0	0	0	0	0	0	0	0	0	3,235	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(25,070)	(150,260)	0	0	0	0	0	0	0	0	0	(175,330)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number | 4 | Report Period Beginning: | Ending:

VII. RELATED PARTIES

Show Pgs 6A | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule - Page 2S		GF-AdCare Convalescent Center, Inc.	Godfrey	Nursing Home Mngrs.	Springfield	Management
		Hilltop Nursing Home, Inc.	Charleston			
		Jacksonville Convalescent Center, Inc.	Jacksonville			
		Menard Convalescent Center, Inc.	Petersburg			
		Interim Manor of Virden, Inc.	Virden			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference:		Sum_6
	Schedule V	Line	Item		Amount	Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	35	Management Fees	$	159,230	Nursing Home Managers, Inc.		94.68%		$ (159,230)	1	-159230
2	V	Year	See Attached Schedule			Nursing Home Managers, Inc.			73,091	73,091	2	73891
3	V	35	Accounting			Nursing Home Managers, Inc. -- Bkwr Allocation			8,978	8,978	3	8978
4	V	24	Travel		312	To transfer 33% of Home Office Travel				(312)	4	-312
5	V	37	Administrative Travel			To Administrative per prior desk review			312	312	5	312
6	V										6	
7	V										7	
8	V										8	0
9	V										9	0
10	V										10	
11	V										11	
12	V										12	
13	V										13	
14	Total			$	159,542				$ 83,173	$ * (76,369)	14	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number # Report Period Beginning: Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6A

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6E

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number # Report Period Beginning: Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6E

Print Preview

* Total must agree with the amount recorded on line 34 of Schedule VI.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6F

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number # Report Period Beginning: Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6F

Print Preview

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6G

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6G

Print Preview

* Total must agree with the amount recorded on line 34 of Schedule VI.

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6H

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number # Report Period Beginning: Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6H

Print Preview

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6I

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number # Report Period Beginning: Ending:

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6I

Print Preview

* Total must agree with the amount recorded on line 34 of Schedule VI.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number # Report Period Beginning: Ending:

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sam Klein	President		31.13%					$ 1,986	17-7	1
2	H. Raymond Klein	Owner		23.35%					1,986	17-7	2
3											3
4											4
5			Sam Klein and H. Raymond Klein were paid by Nursing Home Managers, Inc.								5
6			a related organization. Total compensation of $10,010 for each Sam Klein								6
7			and H. Raymond Klein was allocated among the six related nursing homes								7
8			based upon 10 hours per week for Sam Klein and 10 hours per week for								8
9			H. Raymond Klein.								9
10											10
11											11
12											12
13								TOTAL	$ 3,972		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nursing Home Managers, Inc.
Street Address: 2653 West Lawrence - Suite B
City / State / Zip Code: Springfield, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		SEE ATTACHED SCHEDULES								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8A

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
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19										19
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21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8B

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8C

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
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23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8E

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
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23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8F

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
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24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8G

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
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23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8H

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
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23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8I

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
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23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Firstar Bank		X	Working Capital	Interest	08/25/99	200,000	289,726	08/25/00	Varies	24,522	6
7												7
8												8
9	TOTAL Facility Related						$ 200,000	$ 289,726			$ 24,522	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 200,000	$ 289,726			$ 24,522	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 37,324	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1998	$ 27,993	2
3. Under or (over) accrual (line 2 minus line 1).		$ (9,331)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,235	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 27,904	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	26,016	8
	1996	27,292	9
	1997	27,798	10
	1998	27,993	11
	1999	27,926	12

Line 4: Accrual 16/12 x $27,926 = $37,235

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,452 B. General Construction Type: Exterior Masonry Frame Steel & Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1963	$ 3,000	1
2	Nursing Home		1984	40,077	2
3	TOTALS			$ 43,077	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	50		1963	1958	$ 226,688	$	25	$	$	$ 226,688	4
5	51			1967	289,148		30			289,148	5
6	49			1970	227,964		25			227,964	6
7											7
8											8
	Improvement Type**										
9	Improvement			1979	5,775		15			5,775	9
10	Improvement			1980	1,810		Various			1,810	10
11	Improvement			1980	5,207		Various			5,207	11
12	Improvement			1981	635		10			635	12
13	Improvement			1982	36,795		15			36,795	13
14	Roof			1984	3,000		15			3,000	14
15	Improvement			1984	15,420	857	15	513	(344)	15,420	15
16	Improvement			1984	44,410	1,776	15	1,490	(286)	44,410	16
17	Improvement			1986	13,401	697	15	893	196	12,949	17
18	Improvement			1985	2,016	106	15	135	29	1,944	18
19	Boiler			1986	966	50	15	64	14	870	19
20	Roof			1987	1,878	60	15	125	65	1,635	20
21	Air Conditioner			1987	3,749	160	15	250	90	3,375	21
22	Improvement			1987	6,721	213	15	448	235	5,675	22
23	Improvement			1987	2,539	81	15	169	88	1,521	23
24	Improvement			1988	3,588	114	15	239	125	2,151	24
25	Sprinkler			1989	890	28	15	59	31	531	25
26	Improvement			1989	16,132	512	15	1,076	564	11,289	26
27	Improvement			1990	4,004	127	15	267	140	2,403	27
28	Improvement			1989	12,205	388	15	814	426	8,547	28
29	Improvement			1989	842	27	15	56	29	504	29
30	Improvement			1990	22,907	727	Various	987	260	9,059	30
31	Improvement			1990	24,924	791	Various	1,320	529	12,540	31
32	Improvement			1993	2,576	82	15	172	90	1,290	32
33	Improvement			1993	3,604	115	15	240	125	1,800	33
34	Improvement			1994	1,475	47	15	98	51	637	34
35	Improvement			1995	42,600	1,092	20	2,130	1,038	11,715	35
36	TOTAL (lines 4 thru 35)				$ 1,023,869	$ 8,050		$ 11,545	$ 3,495	$ 947,287	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvement			1995	2,471	63	15	165	102	907	9
10	Air Conditioner			1996	6,844	176	15	456	280	2,052	10
11	Smoke Detectors			1996	981	25	15	65	40	296	11
12	Sinks & Faucets			1996	2,698	69	15	180	111	810	12
13	Windows			1996	3,859	99	15	257	158	1,157	13
14	Fire Door			1996	784	20	15	52	32	234	14
15	Air Conditioner			1997	7,569	194	15	505	311	1,262	15
16	New Door Frames			1997	10,035	257	15	669	412	1,672	16
17	Sprinkler Repairs			1997	1,127	29	15	75	46	188	17
18	Fire Door			1998	808	20	15	54	34	81	18
19	Air Conditioner			1998	1,820	47	15	121	74	182	19
20	Fire Alarm System			1999	8,250	212	20	413	201	619	20
21	Backflow Valve			2000	1,999	2	15	11	9	11	21
22	Water Heater			2000	3,813	29	15	85	56	85	22
23	Backflow Valve			2000	3,998	4	15	22	18	22	23
24	Air Conditioner			1999	2,985	67	15	182	115	182	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 60,041	$ 1,313		$ 3,312	$ 1,999	$ 9,760	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
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8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number # Report Period Beginning: Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 155,960	$ 15,642	$ 15,529	$ (113)	Various	$ 81,245	37
38	Current Year Purchases	16,036	2,292	413	(1,879)	Various	413	38
39	Fully Depreciated Assets	252,737					252,737	39
40	Assets No Longer in Service	(79,615)					(79,615)	40
41	TOTALS	$ 345,118	$ 17,934	$ 15,942	$ (1,992)		$ 254,780	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,472,105	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 27,297	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 30,799	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 3,502	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,211,827	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 84

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		90		90
3	Classroom Wages (a)	1,267	840		2,107
4	Clinical Wages (b)	239	1,236		1,475
5	In-House Trainer Wages (c)				
6	Transportation		526		526
7	Contractual Payments	1,409	3,147		4,556
8	Nurse Aide Competency Tests		150		150
9	TOTALS	$ 2,915	$ 5,989	$	$ 8,904
10	SUM OF line 9, col. 1 and 2 (e)	$ 8,904			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	10

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	39					4,290		4,290	13
14	TOTAL			$		$	$ 4,290		$ 4,290	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number **#** **Report Period Beginning:** **Ending:**

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 63,826	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	177,121		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,417		6
7	Other Prepaid Expenses	4,314		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 268,678	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	43,077		13
14	Buildings, at Historical Cost	1,083,910		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	421,662		16
17	Accumulated Depreciation (book methods)	(1,287,721)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 260,928	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 529,606	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 63,999	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	289,726		29
30	Accrued Salaries Payable	24,346		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,754		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,235		32
33	Accrued Interest Payable	421		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	993		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 431,474	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 431,474	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 98,132	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 529,606	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 61,323	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 61,323	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	36,809	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 36,809	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 98,132	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,990,370	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,990,370	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	4,290	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,290	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	865	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	4,200	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	500	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,565	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	267	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 267	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending $1,975 Admit Fees $1,650	3,625	28
28a	Wage Assignments $40	40	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,665	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,004,157	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 503,710	31
32	Health Care	841,770	32
33	General Administration	459,795	33
	B. Capital Expense		
34	Ownership	79,723	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,967,348	40
41	**Income before Income Taxes (line 30 minus line 40)****	36,809	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 36,809	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 41,767	$ 20.08	1
2	Assistant Director of Nursing	2,031	2,079	34,894	16.78	2
3	Registered Nurses	3,399	3,597	61,073	16.98	3
4	Licensed Practical Nurses	22,697	23,868	271,688	11.38	4
5	Nurse Aides & Orderlies	41,320	42,691	320,751	7.51	5
6	Nurse Aide Trainees	696	696	3,582	5.15	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,024	2,084	16,414	7.88	8
9	Activity Director	1,171	1,462	9,885	6.76	9
10	Activity Assistants	2,306	2,316	12,289	5.31	10
11	Social Service Workers	1,139	1,201	10,890	9.07	11
12	Dietician					12
13	Food Service Supervisor	2,150	2,305	23,733	10.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,236	13,733	84,242	6.13	15
16	Dishwashers					16
17	Maintenance Workers	5,688	5,944	43,023	7.24	17
18	Housekeepers	6,622	6,875	38,596	5.61	18
19	Laundry	4,160	4,281	23,716	5.54	19
20	Administrator	2,000	2,080	45,127	21.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,728	2,788	16,555	5.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	2,798	2,846	14,741	5.18	33
34	TOTAL (lines 1 - 33)	118,162	122,924	$ 1,072,966 *	$ 8.73	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

Print Preview

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	192	$ 3,456	1-3	35
36	Medical Director	240	12,000	9-3	36
37	Medical Records Consultant	17	485	10-3	37
38	Nurse Consultant	120	5,999	10-3	38
39	Pharmacist Consultant	48	1,200	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	50	2,835	12-3	45
46	Other(specify)				46
47	Administrative Consultant	348	8,694	17-3	47
48					48
49	TOTAL (lines 35 - 48)	1,015	$ 34,669		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$ 0		53

Facility Name & ID Number # Report Period Beginning: Ending:

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ron Dallstream	Administrator	0.00%	$ 45,127
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 45,127

B. Administrative - Other

Description	Amount
Administrative Consultant	$ 8,694
TOTAL (agree to Schedule V, line 17, col. 3)	$ 8,694
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Nursing Home Managers, Inc.	Management	$ 159,230
CSC	Corp. Representation	396
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 159,626

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 14,556
Unemployment Compensation Insurance	16,143
FICA Taxes	80,588
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
HBV Vaccine	2,838
Section 125 Plan	20,950
Employee Life Insurance	2,241
Gift Certificates	1,035
Employee Party & Appreciation	523
Nursing Home Managers Allocation	9,297
TOTAL (agree to Schedule V, line 22, col.8)	$ 148,171

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HBV Vaccine	22	$ 2,838
Gift Certificates	22	1,035
Employee Party & Appreciation	22	523
TOTAL		$ 4,396

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	4,070
Health Care Worker Background Check	936
(Indicate # of checks performed 78)	
See Attached Schedule - Page 26	4,669
Nursing Home Managers Allocation	193
Less: Non-Allowable Dues	(60)
Less: Public Relations Expense	(3,147)
Non-allowable advertising	( )
Yellow page advertising	(819)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,042

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Administrator Mileage Reimbursement	421
Misc. Mileage Reimbursement	255
Nursing Home Managers Allocation	696
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,372

**See instructions.

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting	Various	$ 4,140	36 MO	$	$	$	$	$	$	$	$	$
2	Painting	Various	2,260	36 MO									
3	Painting	Various	2,090	36 MO									
4	Painting	Various	1,690	36 MO									
5	Paint & Wallpaper	Various	4,650	36 MO	775								
6	Paint & Wallpaper	Various	3,255	36 MO	1,085	542							
7	Paint & Wallpaper	10/95	3,414	36 MO	1,138	1,138	569						
8	Paint & Wallpaper	5/96-4/97	5,617	36 MO	936	1,872	1,872	937					
9	Paint & Wallpaper	5/97-4/98	2,685	36 MO		448	895	895	447				
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 29,801		$ 3,934	$ 4,000	$ 3,336	$ 1,832	$ 447	$	$	$	$

Print Preview

Facility Name & ID Number # Report Period Beginning: Ending:

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **13 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **$ 542** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **$ 82,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

Schedule V - Pages 3&4

Line 27 Other General Administration

Bad Debts	$	7257
Sales Tax		3412
Fines		6727
Illinois RT Tax		993
Line 27	$	18389

Column 5 Detail of Reclassifications

		Amount	Line #
From: Oxygen	$	-4290	10
To: Ancillary Services	$	4290	39
To: Administrative Consultant Mileag	$	696	17
Nurse Consultant Mileage		243	10
From: Travel	$	-939	24

Line 23 Inservice Training & Education

Dental Care Inservice	$	219
Activity Course		725
Nursing Monthly		310
Educational Material		65
Dietary Inservice		30
INHAA Convention		125
Housekeeping & Maintenance Conf.		40
Diabetes Conference		60
Food Service Sanitation Seminar		89
Alzheimer Conference		90
MDS Seminar		50
Meals and Travel Reimbursement		136
Nursing Home Managers Allocation		167
Total Line 23 Column 8	$	2106

Page 6 - Schedule VII - Column 1
Related Party - Owners

	Ownership %
H. Raymond Klein	23.34615
Sam Klein	31.13462
Esther Wolfson, Trustee - Trust B	27.34615
Gerda Hagen	3.65385
Ignacio & Mary Del Valle	6.73077
Philip Klein	1.73077
Dana Klein	1.73077
Lisa Gildar	1.73077
Alyce Klein	2.59615
	100

Page 13 - Schedule XI - Section E
Reconciliation of Depreciation

Schedule XI - Section E - Line 49	$	30799
Nursing Home Managers Allocation		1716
Schedule V - Line 30 - Column 8	$	32515

Page 15 - Schedule XIII

Trained at: Sunrise Manor of Virden, Inc.
333 South Wrightsman
Virden, IL 62670

Cost per Aide Trained: 6 @ $524.50

Page 19 - Schedule XVII
Reconciliation of Income

Line 43 - Net Income	$	36809
*Management Fee 4/99		-12576
*Management Fee 4/00		13172
Interest Income		-267
Rental Income		-4600
Taxable Income	$	32538

* Related party accounts payable not allowed for tax purposes are included here for consistancy with prior year cost reports and to conform with accrual accounting methods.

Page 21 - Schedule XIX - Section F
Dues, Fees, Subscriptions, and Promotions

Yellow Pages	$	819
Public Relations		3147
Optimist Club Dues		60
FSS License		70
Franchise Fees		323
HCFA Lab Fees		150
Administrator License		100
	$	4669

Page 23 - Schedule XX
Question # 12

Salary costs are allocated to department based upon hours worked per time cards.

CENTRAL OFFICE COST ALLOCATION
MEADOW MANOR
1999

	MAY 99	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN 00	FEB	MARCH	APRIL	1999 TOTAL	Reference #
SALARIES-ADMIN	$2,553	$2,651	$2,614	$2,847	$2,884	$2,965	$3,040	$2,969	$2,856	$2,784	$2,724	$2,748	$33,634	17
SALARIES-CLERIC	1,132	1,176	1,160	1,408	1,427	1,467	1,504	1,469	1,465	1,428	1,397	1,410	16,443	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	0	0	0	93	94	97	99	97	0	0	0	0	479	10
ACCOUNTING	21	22	22	27	27	28	29	28	9	9	9	9	240	19
WORK COMP INS	7	7	7	5	5	5	5	5	15	15	15	15	104	22
SUPPLIES	89	93	91	63	64	66	67	66	139	136	133	134	1,140	21
TELEPHONE	48	50	49	54	55	57	58	57	66	65	63	64	685	21
EMPL BENEFITS	405	421	415	434	440	452	464	453	472	460	450	454	5,320	22
PAYROLL TAXES	264	274	270	329	333	343	351	343	351	342	335	338	3,873	22
TRAVEL	17	17	17	33	34	35	36	35	202	196	192	194	1,008	24
IN SERVICE	28	30	29	5	5	5	6	5	14	13	13	13	167	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	14	14	14	3	3	4	4	4	22	21	21	21	145	6
OWNERS COMP	315	327	322	330	334	344	352	344	335	327	320	322	3,972	17
INS-PROP,LIAB,WC	22	22	22	23	23	24	25	24	24	24	23	23	279	26
DEPRECIATION	129	134	132	139	140	144	148	145	156	152	148	150	1,716	30
RENT	316	329	324	320	324	333	342	334	344	336	328	331	3,962	34
MAINTENANCE	14	15	15	73	74	76	78	76	28	27	27	27	531	6
FEES & PUBLICAT	5	5	5	28	29	30	30	30	5	5	5	5	182	20
ADVERTISING	0	0	0	0	0	0	0	0	3	3	3	3	11	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$5,378	5,585	$5,507	$6,215	$6,297	$6,474	$6,637	$6,484	$6,507	$6,341	$6,205	$6,261	$73,891	
FIXED ASSETS		0												
EQUIP - PRIOR	10,321	10,718	10,568	10,549	10,687	10,988	11,264	11,004	9,323	9,085	8,890	8,971	10,197	
EQUIP - CURR	0	0	617	1,351	1,369	1,408	1,443	1,410	1,886	2,231	4,093	4,130	1,662	
EQUIP - FULLY DEP	1,070	1,111	1,096	1,094	1,108	1,139	1,168	1,141	1,140	1,111	1,087	1,097	1,114	
BLDG - PRIOR	1,282	1,331	1,313	1,310	1,328	1,365	1,399	1,367	1,366	1,331	1,302	1,314	1,334	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

MEADOW MANOR #0011528
5/01/99 TO 4/30/00

OCCUPIED DAYS 1999	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,678	2,190	2,298	2,108	599	1,557	2,603	14,033
FEBRUARY	2,471	1,935	2,036	1,894	594	1,322	2,314	12,566
MARCH	2,681	2,164	2,223	2,021	633	1,397	2,364	13,483
APRIL	2,482	1,983	2,120	1,906	596	1,351	2,421	12,859
MAY	2,586	1,928	2,189	1,871	615	1,472	2,379	13,040
JUNE	2,349	1,864	2,168	1,899	583	1,418	2,256	12,537
JULY	2,331	1,911	2,239	1,894	601	1,432	2,373	12,781
AUGUST	2,345	1,839	2,144	1,848	612	1,471	2,366	12,625
SEPTEM	2,298	1,790	2,105	1,786	643	1,561	2,121	12,304
OCTOBER	2,391	1,815	2,097	1,820	725	1,657	2,034	12,539
NOVEMBEF	2,316	1,775	2,004	1,831	692	1,510	1,998	12,126
DECEMBEF	2,415	1,834	2,136	1,881	692	1,552	2,148	12,658
TOTAL	29,343	23,028	25,759	22,759	7,585	17,700	27,377	153,551
								153,551

ALLOCATION PERCENTAGE 1999	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	19.08%	15.61%	16.38%	19.29%	11.10%	18.55%	100.00%
FEBRUARY	19.66%	15.40%	16.20%	19.80%	10.52%	18.41%	100.00%
MARCH	19.88%	16.05%	16.49%	19.68%	10.36%	17.53%	100.00%
APRIL	19.30%	15.42%	16.49%	19.46%	10.51%	18.83%	100.00%
MAY	19.83%	14.79%	16.79%	19.06%	11.29%	18.24%	100.00%
JUNE	18.74%	14.87%	17.29%	19.80%	11.31%	17.99%	100.00%
JULY	18.24%	14.95%	17.52%	19.52%	11.20%	18.57%	100.00%
AUGUST	18.57%	14.57%	16.98%	19.49%	11.65%	18.74%	100.00%
SEPTEMBER	18.68%	14.55%	17.11%	19.74%	12.69%	17.24%	100.00%
OCTOBER	19.07%	14.47%	16.72%	20.30%	13.21%	16.22%	100.00%
NOVEMBER	19.10%	14.64%	16.53%	20.81%	12.45%	16.48%	100.00%
DECEMBER	19.08%	14.49%	16.87%	20.33%	12.26%	16.97%	100.00%

OCCUPIED DAYS 2000	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	2,453	1,828	2,186	1,874	663	1,482	2,008	12,494
FEBRUARY	2,205	1,686	2,168	1,746	597	1,442	1,996	11,840
MARCH	2,383	1,773	2,434	1,904	604	1,569	2,285	12,952
APRIL	2,273	1,671	2,387	1,783	641	1,496	2,155	12,406
MAY	2,301	1,691	2,252	1,910	600	1,448	2,073	12,275
JUNE	2,211	1,730	2,175	1,793	603	1,426	1,906	11,844
JULY	2,317	1,823	2,396	1,846	652	1,459	1,889	12,382
AUGUST								0
SEPTEM								0
OCTOBER								0
NOVEMBER								0
DECEMBER								0
TOTAL	16,143	12,202	15,998	12,856	4,360	10,322	14,312	86,193
								86,193

ALLOCATION PERCENTAGE 2000	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	19.63%	14.63%	17.50%	20.31%	11.86%	16.07%	100.00%
FEBRUARY	18.62%	14.24%	18.31%	19.79%	12.18%	16.86%	100.00%
MARCH	18.40%	13.69%	18.79%	19.36%	12.11%	17.64%	100.00%
APRIL	18.32%	13.47%	19.24%	19.54%	12.06%	17.37%	100.00%
MAY	18.75%	13.78%	18.35%	20.45%	11.80%	16.89%	100.00%
JUNE	18.67%	14.61%	18.36%	20.23%	12.04%	16.09%	100.00%
JULY	18.71%	14.72%	19.35%	20.17%	11.78%	15.26%	100.00%

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.32%	13.47%	19.24%	19.54%	12.06%	17.37%	100.00%
SALARIES-ADMIN	$2,577	$1,895	$2,706	$2,748	$1,696	$2,443	$14,066
SALARIES-CLERIC	1,322	972	1,388	1,410	870	1,253	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	8	6	9	9	6	8	$46
WORK COMP INS	14	10	14	15	9	13	$75
SUPPLIES	125	92	132	134	83	119	$685
TELEPHONE	60	44	63	64	39	57	$326
EMPL BENEFITS	426	313	447	454	280	404	$2,324
PAYROLL TAXES	317	233	333	338	209	300	$1,730
TRAVEL	182	134	191	194	120	172	$993
IN SERVICE	12	9	13	13	8	12	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	21	21	13	19	$108
OWNERS COMP	302	222	317	322	199	287	$1,650
INS-PROP,LIAB,WC	22	16	23	23	14	21	$120
DEPRECIATION	140	103	147	150	92	133	$766
RENT	311	228	326	331	204	295	$1,696
MAINTENANCE	25	19	26	27	17	24	$137
FEES & PUBLIC	5	3	5	5	3	4	$25
ADVERTISING	2	2	3	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$5,871	$4,316	$6,165	$6,261	$3,864	$5,566	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,412	6,184	8,834	8,971	5,536	7,975	45,912
EQUIP - CURR	3,873	2,847	4,067	4,130	2,549	3,672	21,138
EQUIP - FULLY DEP	1,029	756	1,080	1,097	677	975	5,614
BLDG - PRIOR	1,232	906	1,294	1,314	811	1,168	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0